CLAIM REOPENING APPLICATION FOR TEMPORARY TOTAL DISABILITY OR MEDICAL TREATMENT

PLEASE PRINT OR TYPE

Step 1 Claimant – Complete Section I and take this form to your doctor.
Step 2 Physician – Complete Section III and return this form to the claimant for delivery to employer at time of injury.
Step 3 (Optional) Claimant – Take this form to the employer for whom you worked at the time of your injury to complete Section II.

SECTION I – TO BE COMPLETED BY CLAIMANT

1. Claimant's Name (First, Middle, Last)	**2.** Social Security Number – Last four digits only.	**3.** Date of Injury
4. Mailing Address (Street or P.O. Box, City, State, Zip)	**5.** Telephone Number (include area code)	**6.** Claim Number

7. Please check the appropriate box:
I am requesting Medical Treatment and/or additional Temporary Total Disability (TTD)/Wage Replacement benefits due to:
____ Aggravation and/or progression of condition or disability resulting from the compensable injury or occupational disease.
____ Fact or factors pertaining to the disability or condition not previously considered.

8. Have you suffered any other illness and/or injuries since the injury upon which this claim is based? ____ Yes ____ No
If yes, specify the nature of the illness and/or injuries, the dates of the illness and/or injuries. Please list the names and address of the physician(s) who treated you.

9. Have you filed any other workers' compensation claim in West Virginia or any other state? ____ Yes ____ No
If yes, list all claim numbers and/or dates of injuries or occupational disease.

10. Have you drawn either unemployment or other wage replacement benefits since you were last paid TTD benefits in this claim?
____ Yes ____ No If yes, please state the source(s) and for what time periods you received other benefits.

11. Have you earned wages since you were last paid TTD benefits in this claim? ____ Yes ____ No
If yes, please list who you worked for and proved time periods of earned wages.

12. Have you retired? ____ Yes ____ No If yes, please list employer's name and any benefits *(i.e. Social Security, pension, etc.)* you are receiving.

13. Claimant's Signature	**Date**

SECTION II
EMPLOYER - Optional

1. Employer's Name, Address and Telephone Number *(include area code)*	**2.** Do you disagree with any of the information contained in Section I or III of this form? ____ Yes ____ No If yes, explain the information with which you disagree. Be specific.
3. The claimant began missing work again on:	**4.** The employer waives the 10-day notice period and does not object to an immediate ruling on the claimant's petition. ____ Yes ____ No

5. Employer's Signature	**Title**	**Date**

SECTION III – TO BE COMPLETED BY THE PHYSICIAN IN DETAIL AND A NARRATIVE REPORT ATTACHED IF NECESSARY

1. Physician's Name, Address and Telephone Number	**2.** Physician's FEIN or Vendor Number
3. Are you the previously authorized attending physician in this claim? ____ Yes ____ No	**4.** Date of examination upon which these findings are based:

5. List the current diagnosis (include specific ICD9/10-CM codes and description), and indicate if you are requesting that a new body part be added.

6. List the claimant's complaints as it relates to the compensable injury or occupational disease.

7. Has there been an aggravation or progression of the claimant's disability since being released to resume employment or being certified as having reached maximum degree of medical improvement? ____ Yes ____ No

If yes, list the physical findings that relate to the aggravation/progression of the injury or occupational disease. Please indicate the date and location for any diagnostic testing that was administered, as well as the results.

8. List any requests for authorizations as it relates to the compensable injury or occupational disease. Please attach any office notes or medical reports.

9. Can the claimant now perform regular duty? ____ Yes ____ No If no, under what restrictions could the claimant work?

If yes, list any work restrictions on the patient's functional abilities.

10. Please list exact periods of Temporary Total Disability: From _____ To _____

11. Physician's Signature	**Date**